STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145044	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allure of Peru	1301 21st Street Peru, IL 61354

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 33973 Based on observation, interview, and record review the facility failed to provide a resident with a mirror to allow for self grooming for one (R66) of one resident reviewed for Accommodations of Need in a sample of 35. Findings include: The facility's Activities of Daily Living (ADLs) policy, dated 7/1/23, documents The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care. On 5/13/24, at 9:40am, R66 was lying in bed with visible facial hair. R66 stated I can't see myself in the mirror from my wheelchair, only from the forehead up. It is part of the reason I haven't shaved. I know it (my beard) looks bad. R66's Care plan includes a focus of: (R66) is at risk for an ADL Self Care Performance Deficit related to Activity Intolerance, Impaired balance, bilateral AKA (Above the Knee Amputation). The goal is: (R66) will improve current level of function in Bed Mobility, Transfers, Eating, Dressing, Toilet Use and Personal Hygiene through the review date. The interventions include: Encourage (R66) to participate to the fullest extent possible with each interaction. On 5/14/24, at 2:20pm V13 Restorative Nurse stated (R66) is capable of shaving himself and would need a mirror to do so. V13 was unaware that R66 could not see himself in his mirror on the wall. On 5/15/24, at 3:15pm, R66 sat in his electric wheelchair facing and across from the sink with a mirror above it. R66 adjusted the position of the back of his wheelchair up higher and stated I can't see my chin no matter what.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 34048 Based on interview and record review the facility failed to implement a person centered baseline care plan for two residents (R281 and R283) of five reviewed for baseline care plans in a sample of 35. Findings include: The facility's Baseline Care Plan, undated, documents that the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care. R281's admission orders, dated 5/4/24, documents the following diagnosis: fracture of the neck of the left femur, acute urinary tract infection, acute metabolic encephalopathy, dementia, hard of hearing, lacunar stroke and mild aortic insufficiency. R281's base line care plan does not address R281's personalized needs. R283's Progress Notes, dated 5/10/24 documents that R283's referral (to another facility) was denied due to R283's history of suicidal ideation's. On 05/14/24 at 2:00pm, R283 stated that she had some concerns a while back with suicidal ideation's and mental disorders. On 5/15/24 at 1:45pm, V18, Care Plan Director, stated that the base line care plans is a check off list and not personalized. V18 verified that R281 and R283's base line do not address all of their needs. On 5/15/24 at 2:00pm, V4, Social Service Director, stated that R283 has a history of suicidal ideations in the past. V4 verified that R283's current care plan does not address this issue.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33973 Based on observation, interview, and record review the facility failed to ensure an order was placed and a resident was wearing a recommended assistive device for one (R62) of one resident reviewed for Limited Range of Motion in a sample of 35. Findings include: The facility's Prevention of Decline in Range of Motion policy, dated 7/1/23, documents 3. Appropriate Care Planning. a. Based on the comprehensive assessment the facility will provide interventions, exercises and/or therapy to maintain or improve range of motion. b. The facility will provide treatment and care in accordance with professional standards of practice. This includes, but is not limited to: i. Appropriate services (specialized rehabilitation, restorative, maintenance). ii. Appropriate equipment (braces or splints). R62's current Face Sheet documents R62 admitted on [DATE] with an admitting diagnosis of Hemiplegia and Hemiparesis following other Cerebrovascular Disease affecting left non-dominant side. On 5/13/24, at 9:28am, R62 was sitting in a reclining chair in her room with a flaccid left arm and hand at her side. A splint device is sitting on the bedside table near her. R62 stated I have a hard time getting someone to put it on. I can't do it myself. It is supposed to be four hours on four hours off. I have been up since 5 and haven't had it on yet. I had a stroke and can not move my left arm. On 5/13/24, at 11:32am, V19 Certified Nursing Assistant/CNA stated V19 assisted in getting R62 up today around 7:45am. V19 verified V19 did not put R62's splint on her hand and should have. V19 stated I guess I was in a hurry. R62's Minimum Data Set/MDS assessment, dated 3/27/24, documents splint in use 7 days/week. R62's Care Plan, dated 10/13/23, documents (R62) is a risk for an ADL (Activities of Daily Living) Self Care Performance Deficit related to Activity Intolerance, Left Hemiplegia status post stroke, Impaired balance. The interventions include: Restorative: Splint/Brace - (R62) is to wear left hand splint as ordered by therapy. Assist in donning brace. On in AM at 7:00, off at 12:00 and on in PM at 4:00, off at 9:00pm daily. The goal is to prevent left hand tendon shortening and contracture. R62's Order Request for Occupational Therapy, dated 10/13/23, documents: Reason for request/Treatment diagnosis: Prevention of tendon shortening and contracture; preventions while left hand at rest. Frequency: 2 times a day. Duration: 5 hours. To receive assistance donning left wrist hand resting hand splint. R62's current Physician Order Sheet/POS does not include an order for a splint. On 5/13/24, at 3:43pm, R62 is in a wheelchair in her room with her left arm lying at her side without a splint. R62's splint is lying on the bedside table in front of her. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/24, at 2:27pm, V12 Director of Rehab stated We give our orders to Restorative Nursing and she puts the order in. On 5/14/24, at 2:30pm, V13 Restorative Nurse stated that V13 put (R62's) splint order in on 10/13/23. (R62's) orders were discontinued in February after a hospitalization and V13 didn't see it to put it back in R62's POS (Physician Order Sheet). V13 stated that staff should be putting (R62's) splint on her.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 33973 Based on interview and record review the facility failed to ensure psychotropic medication ordered PRN (as needed) was limited to 14 days for one (R39) of three residents reviewed for Unnecessary Medications in a sample of 35. Findings include: The facility's undated policy, Use of Psychotropic Medication documents, Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record, and the medication is beneficial to the resident as demonstrated by monitoring and documentation of the resident's response to the medications(s). This policy also states 9. PRN (as needed) orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order. R39's Physician Order Sheet/POS includes diagnoses of Dementia with Psychotic Disturbance and Adjustment Disorder with Mixed Anxiety and Depressed Mood. R39's POS also includes an order for Lorazepam Oral Tablet 0.5mg, dated 4/29/23. Give 1 tablet by mouth every 8 hours as needed for Anxiety related to Adjustment Disorder with Mixed Anxiety and Depressed Mood for 90 days. The ending order date is documented as 7/28/24. On 5/16/24, at 11:00am, V2 Director of Nursing/DON was unable to produce documentation by R39's physician for extended use of Lorazepam.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32061 Based on observation, interview and record review, the facility failed to administer medications as ordered by the physician for two residents (R58 and R72) on the sample of 7 residents reviewed for medication pass. This failure resulted in two medication errors out of twenty- five opportunities for error, for an 8% medication error rate. FINDINGS INCLUDE: The facility policy, Medication Administration, dated (7/1/23) directs staff, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Ensure the six rights of medication administration are followed: right resident, right drug, right dosage, right route, right time and right documentation. 1. R58's current Physician Order Sheet, dated May 2024 includes the following medications: Carafate (anti-ulcer) 1 GM (Gram) by mouth three times daily. On 5/13/24 at 11:16 A.M., V6 Registered Nurse (RN) prepared to administer medications for R58. V6 placed one capsule of Gabapentin 100 MG (Milligrams) in a plastic medication cup. V6 then removed one tablet of Sucralafate 1 GM from a punch card, with written instructions on the card, Take 2 hours before or 2 hours after other medications, placed it in the medication cup and then added Lasix 20 MG one tablet to the same cup. V6 entered R58's room, handed R58 the medication cup with three pills to R58 who immediately took the three pills together with a drink of water, Upon exiting R58's room, V6 verified the Sucralfate should have been given 2 hours before or 2 hours after the other medications. 2. R72's current Physician Order Sheet, dated May 2024 includes the following diagnoses: Osteomyelitis Of Vertebra, Thoracic Region; Methicillin Resistant Staphylococcus Aureus Infection; Type 2 Diabetes Mellitus. This same sheet includes the following medications: Vancomycin HCl ((Hydrochloride)Intravenous Solution 2500 mg intravenously in the morning. On 5/14/24 at 8:20 A.M., V6 mixed 20 ML (Milliliters) of Sterile Water into (3) vials of Vancomycin 1 GM (Gram) powder. V6 then withdrew all 20 ML of 2 bottles and 10 ML of the third bottle and injected the mixed solution into the 500 ML bag of Normal Saline, equaling a total of 550 ML. with 2500 MG of Vancomycin. V6 entered (R72's) room and programmed (R72's) IV (Intravenous) pump for 500 ML of fluid over 180 minutes. On 05/14/24 12:08 P.M., V6 returned to R72's room to disconnect the IV (intravenous) Vancomycin and flush (R72's) PICC (Peripherally Inserted Central Catheter) line. V6 disconnected (R72's) Vancomycin bag with 50-60 ML (Milliliters) of Vancomycin mixture remaining. V6 flushed the PICC line with Normal Saline, then Heparin and disposed of the Vancomycin IV bag with the remaining fluid., in the trash can. At that time, V6 verified the remaining IV medication in the bag and stated, The directions are to infuse (the bag) (500 ML Normal Saline) at 200 CC/HR for 180 minutes. I guess that doesn't take into account the additional 50 ML of sterile water with the vancomycin in it.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 32061 Based on observation, interview and record review the facility failed to administer medications as ordered by the physician for one resident (R72) of seven residents reviewed for medication administration, in a sample of 35. The undated facility policy, Intravenous Therapy directs staff, The facility will adhere to accepted standards of practice regarding infusion practices. Review and verify practitioner's order for infusion solution or medication, dose, frequency and route of administration. R72's current Physician Order Sheet, dated May 2024 includes the following diagnoses: Osteomyelitis Of Vertebra, Thoracic Region; Methicillin Resistant Staphylococcus Aureus Infection; Type 2 Diabetes Mellitus. This same sheet includes the following medications: Vancomycin HCl ((Hydrochloride)Intravenous Solution 2500 mg intravenously in the morning. On 5/14/24 at 8:20 A.M., V6 (Registered Nurse/RN) mixed 20 ML (Milliliters) of Sterile Water into (3) vials of Vancomycin 1 GM (Gram) powder. V6 then withdrew all 20 ML of 2 bottles and 10 ML of the third bottle and injected the mixed solution into the 500 ML bag of Normal Saline, equaling a total of 550 ML. with 2500 MG of Vancomycin. V6 entered (R72's) room and programmed (R72's) IV (Intravenous) pump for 500 ML of fluid over 180 minutes. On 05/14/24 12:08 P.M., V6 returned to R72's room to disconnect the IV Vancomycin and flush (R72's) PICC (Peripherally Inserted Central Catheter) line. V6/RN disconnected (R72's) Vancomycin bag with 50-60 ML (Milliliters) of Vancomycin mixture remaining. V6/RN flushed the PICC line with Normal Saline, then Heparin and disposed of the Vancomycin IV bag with the remaining fluid., in the trash can. At that time, V6 verified the remaining IV medication in the bag and stated, The directions are to infuse (the bag) (500 ML Normal Saline) at 200 CC/HR for 180 minutes. I guess that doesn't take into account the additional 50 ML of sterile water with the vancomycin in it. On 5/15/24 at 9:52 A.M., V14 (Pharmacist) stated, The addition of the additional 50 ML of normal saline to the 500 ML bag, the volume of fluid to be infused needs to be adjusted to compensate for the additional 50 ML added, or the resident would not receive the full dose of Vancomycin. I would consider that a significant medication error.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 33973 Based on observation, interview, and record review the facility failed to ensure pureed bread was provided for residents' lunch for three (R19, R38, and R60) of three residents reviewed for Pureed Diets in a sample of 35. Findings include: The facility's undated Explanation of Diets Pureed policy documents Pureed regular bread and specialty breads such as corn bread, muffins, garlic bread, etc., continue to be pureed as a separate menu item. Pureed bread items may be served hot or cold but need to be held at the appropriate temperature throughout the meal service. The facility's undated Week at A Glance with Portion Pureed menu for Week 4 documents the following meal to be served on 5/14/24: Pureed Baked Ham, Pureed Au Gratin (which was substituted with Cheesy Mashed Potatoes), Pureed peas, Pureed bread/margarine and pureed strudel stick. On 5/14/24, between 10:36am -10:48am, V5 Cook/Assistant Manager pureed ham then Brussel sprouts for today's menu. On 5/14/24, at 11:42am , V5 began serving up plates from the steam table. During this time there was no pureed bread on the steam table to be given to residents on pureed diets. On 5/14/24, at 11:50am, V5 stated there is no pureed bread for lunch today. Sometimes I add it to the pureed ham, but I didn't today. R19's current Physician Order Sheet/POS documents and order for Regular diet, Pureed texture, Thin consistency. R38's current POS documents an order for Regular diet, Pureed texture, Thin consistency. R60's current POS documents an order for Regular diet, Pureed texture, Thin consistency. On 5/14/24, at 1:25pm, V3 Dietary Manager/DM stated that V5 should have made and served pureed bread.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32061 Based on observation, interview, and record review the facility failed to utilize PPE (Personal Protective Equipment), failed to perform hand hygiene during medication pass, failed to initiate enhanced barrier precautions and failed to sanitize equipment after usage in an enhanced barrier precaution room for six residents (R2, R12, R32, R58, R14 and R281) of 24 reviewed for infection control. This has the potential to affect 79 residents residing in the facility. Findings include: The facility's Cleaning and Disinfection of Resident-Care Equipment, dated 7/1/23, documents that resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection. This form also documents that multiple-resident use equipment shall be cleaned and disinfected after each use. The facility red Enhanced Barrier Precautions sign from the United States Department of Health and Human Services Centers for Disease Control and Prevention, provided by V11/Infection Preventionist documents, Enhanced Barrier Precautions everyone must clean their hands, including before entering and and when leaving the room. The facility policy, Medication Administration, dated 7/1/23 directs staff, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Remove medication from source, taking care not to touch medication with bare hands. R32's current Physician Order Sheet documents that R32 is on enhanced barrier precautions related to wounds, MRSA (methicillin-resistant staphylococcus aureus) of the nares, and history of MRSA of the wounds. R281's current Physician Order Sheet documents that R281 is on enhanced barrier precautions related to a urinary catheter. This form also documents to cleanse the incision on the left hip and cover with a dry dressing every other evening shift. 1. On 05/14/24 at 9:00am, V15, CNA (Certified Nursing Assistant) and V16, CNA, entered R32's room with a mechanical lift, with only masks on. V15 and V16 exited the room and verified that they did not have the appropriate personal protective equipment on. V15 and V16 transferred R32 with a mechanical lift to the commode and then back to his chair. V15 exited R32's room with the mechanical lift, removed her gloves. V15 then pushed the mechanical lift down the hall to R281's room. On 5/15/24 at 9:00am, V15 verified that the mechanical lift was not cleaned or disinfected after it was used on R32. V15 stated that the facility does not have bleach or disinfecting wipes in the rooms or in the PPE carts outside of the rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. R14's current Physician Order Sheet, dated May 2024 documents R14 was admitted to the facility on [DATE] with the following diagnoses: Type 2 Diabetes Mellitus, Vascular Dementia, Personal History of Urinary Tract Infections, Current Urinary Tract Infection. On 5/11/24 a new physician's order was obtained to place an indwelling urinary catheter, due to urinary retention. On 5/13/24 at 10:04 A.M., R14 was seated in a wheelchair in her room. A urinary catheter bag was hanging from the back of R14's wheelchair with yellow urine present. No Enhanced Barrier Precaution sign was present on the door to R14's room. V8 and V9/Certified Nursing Assistants entered (R14's) room to provide assistance to (R14's) roommate without performing hand hygiene. On 5/15/24 10:30 A.M., V11/Infection Preventionist stated, The criteria for a resident to be placed in EBP (Enhanced Barrier Precautions) is any resident with an indwelling urinary catheter. At that time V11/Infection Preventionist verified that R14 should have been placed in Enhanced Barrier Precautions when the urinary catheter was placed on 5/11/24. 3. On 5/13/24 at 11:16 A.M., V6/Registered Nurse prepared to administer medications for R58. After placing medications in a plastic medication cup, V6/RN entered R58's room without performing hand hygiene, despite the fact an Enhanced Barrier Precaution sign was hanging from R58's room. On 5/13/24 at 11:20 A.M., V6/Registered Nurse prepared to administer medications for R32. After placing medications in a plastic medication cup, V6/RN entered R32's room without performing hand hygiene, despite the fact an Enhanced Barrier Precaution sign was hanging from R32's room. On 5/13/24 at 11:31 A.M., V6/Registered Nurse prepared to administer medications for R2. After placing medications in a plastic medication cup, V6/RN entered R2's room without performing hand hygiene, despite the fact an Enhanced Barrier Precaution sign was hanging from R2's room. Upon exit from R2's room, V6/RN verified she did not perform hand hygiene upon entrance to the resident's rooms despite the Enhanced Barrier Precaution sign with instructions to do so. 4. On 5/13/24 at 11:22 A.M., V6/Registered Nurse (RN) prepared to administer mediations for R12. 6/RN removed one tablet of Gabapentin 100 MG from a prepackaged bubble pack directly into a small, plastic medication cup. V6/RN then removed one tablet of Carafate 1 GM (Gram) from a prepackaged bubble pack directly into her bare hand, broke the tablet in 2 and placed both halves into the small, plastic medication cup. V6/RN then entered R12's room, handed R12 the medication cup which R12 took with sips of water. Upon exit from R12's room, V6/RN verified she had touched R12's medications with ungloved hands. The CMS (Center for Medicare and Medicaid Services) Form 671 dated 5/13/24 documents 78 residents reside in the building.